OMB No: 2900-NEW
Estimated Burden: 10 min.
Expiration Date: xx/xx/xxxx

Department of Veterans Affairs

VETERAN REIMBURSEMENT CLAIM FORM

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-xxxx, and it expires xx/xx/xxxx. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-xxxx in any correspondence. Do not send your completed VA Form 10-320 to this email address.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38 United States Code, Section 1728, and will be used to assist us in determining your entitlement to reimbursement for services rendered. It will not be used for any other purpose. Disclosure is voluntary. However, failure to furnish the information will result in our inability to process your claim. Your failure to furnish this information will have no adverse effect on any other benefit to which you may be entitled. This form and relevant documents need to be sent to the VA Medical Facility where the Veteran is enrolled for medical care.

INSTRUCTIONS: Veterans may use this form to request reimbursement for out-of-pocket expenses that occurred as a result of urgent or emergent non-VA medical care that may be eligible for payment under 38 CFR 17.4025 (Veterans Community Care Program), 38 CFR 17.120 (Unauthorized), 38 CFR 17.1000-1003 (Millennium Bill), and 38 CFR 17.1200--17.1230 (COMPACT Act).

For a claim to be considered for payment, this form must be completed, signed, and submitted to the Veteran's local VA Medical Center in accordance with timely file requirements (see File a Claim - Information for Veterans - Community Care (va.gov)).

SECTION A: VETERAN INFORMATION

1. VETERAN'S NAME *(Last, first, middle initial)*	2. ICN# OR SSN#

3. DATE OF BIRTH *(MM/DD/YYYY)*	4. REFERRAL/AUTHORIZATION NUMBER *(If known)*

5. VETERAN'S ADDRESS *(Include Number and Street, City, State and ZIP Code)*

SECTION B: ITEMIZED BILL REQUIRMENTS

REIMBURSEMENT REQUESTS MUST BE SUBMITTED WITH THE FOLLOWING REQUIRED DOCUMENTS TO BE CONSIDERED FOR PAYMENT:

1. **Pharmacy reimbursement:**
   a. A valid receipt showing the amount paid for the prescription
   b. Name of the medication
   c. Medication dosage/strength
   d. Medication quantity dispensed
   e. Prescribing provider's name
   f. Date the medication was dispensed
   g. Pharmacy name and location

2. **Unauthorized Emergent Medical Care claim reimbursement:**
   a. A valid receipt showing amount paid
   b. Billing statement from the rendering provider showing diagnosis code information
   c. Itemized list of charges with Current Procedural Terminology (CPT) Codes
   d. Rendering Provider National Provider Identifier (NPI) number

For a claim to be considered for payment this form must be completed, signed and submitted to one of the Regional Payment Center locations listed below:

Eastern Region VA Consolidated Payment Center
ATTN 11FB
P.O. Box 5005
Bay Pines, FL 33744

Central Region VA Consolidated Payment Center
P.O. Box 320394
Flowood, MS 39232

Western Region VA Consolidated Payment Center
P.O. Box 1004
Ft Harrison, MT 59636

SECTION C: SIGNED WRITTEN EXPLANATION OF WHY SERVICES WERE NOT OBTAINED THROUGH THE VA

1. EXPLANATION

2. SIGNATURE: I declare under penalty of perjury that the information provided in this form is true and accurate to the best of my knowledge.

3. DATE *(MM/DD/YYYY)*